Title:	**Highlight Report - Promoting Active Ageing**
Wards Affected:	All
To:	Health and Wellbeing Board **On:** 28 January 2020

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Introduction

This report covers four key areas of work under the active ageing programme:

- Ageing Well Torbay
- Age-Friendly Torbay
- Enhanced Health in Care Homes
- Frailty and Falls.

A separate update is presented on each area below.

(1) Ageing Well Torbay: progress & legacy planning

1 Background

1.1 Ageing Well Torbay is a six-year Big Lottery funded programme, designed to reduce social isolation and loneliness in people over 50 in Torbay. The aim is to learn better ways of reaching and overcoming isolation from people's experiences. The programme has four main objectives:

- To reconnect older people with friends, their communities and where they live by creating a sense of neighbourliness;
- To enable more older people to feel their lives have value and purpose, contributing their time, skills and knowledge to the wider community;
- To ensure more older people have high personal, learning and service aspirations for later life;
- To ensure more local residents value older people, and that ageing is celebrated and viewed more positively by all.

2. What has been achieved in the past six months?

2.1 The programme is now entering its final year. Following five years of delivering Community Building (ABCD) in neighbourhoods, trusted relationships have been established with older people in every neighbourhood through a team of community builders fostering people-led change. Their work has been linked to a wider 'ecosystem' that includes social prescribing and collaboratively commissioned partner networks, who add considerable value and reach between all sectors in the bay. This approach has brought together 'siloed' organisations with surprising collaborative outcomes.

2.2 Programme high level outcomes to date are below. These are based on entry and follow-up questionnaires completed by isolated elderly people who have participated in the programme:

- *Loneliness* indicators 0.7 improvement compared with 0.3 improvement across the national programme
- *Social contact family and friends* 0.7 improvement compared with 0.4 improvement across the national programme
- *Social contact local area* 0.25 improvement (0.11 improvement nationally)
- *Social participation in organisations* 0.4 improvement (0.2 improvement nationally)
- *Social activities* 0.46 improvement (0.22 improvement nationally)
- *Wellbeing/mental health* 1.6 improvement (1.4 improvement nationally)
- *Health/quality of life* 0.06 improvement (0.02 improvement nationally)
- *Health self-indicated* scale 5.37 improvement (4.00 improvement nationally)
- *Volunteering* 0.5 improvement
- *Influencing local area decisions* 0.1 improvement.

Ageing Well Torbay			
TORBAY Ecorys statistics summary, sample = 1299 isolated people, Female = 843, Male = 421, 31/12/2019			
ALL PROGRAMMES Ecorys statistics summary, sample = 33,382 isolated people, Female = 21,587, Male = 10,011, 31/12/2019			
Category	**Entry Average**	**Follow-up Average**	**Points Improvement**
Social Isolation and Loneliness De Jong	**3.8** (3.2 ALL)*	**3.1** (2.9 ALL)*	**0.7** ↓ (0.3)*
Social Isolation and Loneliness UCLA	**6.1** (5.5 ALL)*	**5.4** (5.1 ALL)*	**0.7** ↓ (0.4)*
Social Contact - children, family or friends	**3.23** (3.29 ALL)*	**3.48** (3.40 ALL)*	**0.25** ↑ (0.11)*
Social Contact - local area, speak to non-family member	**6.89** (6.66 ALL)*	**7.07** (6.87 ALL)*	**0.18** ↑ (0.21)*
Social Participation - membership of clubs, organisations and societies	**1.1** (1.1 ALL)*	**1.5** (1.3 ALL)*	**0.4** ↑ (0.2)*
Social Participation - How often taking part in social activities compared to others of your age.	**1.24** (1.48 ALL)*	**1.7** (1.7 ALL)*	**0.46** ↑ (0.22)*
Wellbeing - Mental health SWEMWBS (short version)	**20.6** (21.4 ALL)*	**22.2** (22.8 ALL)*	**1.6** ↑ (1.4)*
Health - Quality of Life EQ-5D-3L (five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression)	**0.48** (0.61 ALL)*	**0.54** (0.63 ALL)*	**0.06** ↑ (0.02)*
Health - EQ VAS (self-indicated - "worst possible" to "best possible" health)	**61.94** (62.94 ALL)*	**67.31** (66.94 ALL)*	**5.37** ↑ (4.00)*
Volunteering	**1**	**1.5**	**0.5** ↑
Influencing - personally influence decisions that affect your local area	**2.4**	**2.5**	**0.1** ↑
Participants in AWT programme	**8467**		
Volunteers in AWT Programme	**2016**		
* ALL 14 Programmes			

3. What are the blockages?

3.1 The main challenge for Ageing Well Torbay now is to secure legacy arrangements beyond the conclusion of the programme in 2021.

4. What is the planned activity for the next six months?

4.1 Planning is underway for legacy beyond March 2021. Details for each element of the Ageing Well programme are below:

- *Wellbeing Coordination 50+*: this will continue to delivered by Age UK Torbay and will be fully funded by the NHS. Age UK Torbay and Citizens Advice will partner to deliver services to the under 50s.

- *FAIR (Financial Advice, Information and Resilience):* Citizens Advice are fundraising to continue FAIR and planning to train other organisations in the collaborative model.
- *Torbay Together (Timebank) and Staying Put*: these will continue to develop collaborative and peer volunteering in Torbay.
- *Torbay Older age assemblies (TOFA)*: these are volunteer-led and will continue to grow in Brixham, Paignton and Torquay.
- Torbay Community Development Trust, through Ageing Well Torbay, is producing a range of learning documents.
- The Development Trust is seeking funding to continue to work across age groups and sectors to deliver strength based community development.
- *Community Builders:* all of the Ageing Well partners have acknowledged the valuable work of the Community Builders. This remains the most difficult area to transfer because the work is by necessity often subtle and 'under the radar', building trust with people who have lost trust, growing capacity, and developing connections. There is commitment among partners in the system to maintain the function beyond the life of the programme, and a number of options are currently under discussion with statutory partners.

(2) Age-Friendly Torbay

1 Background

1.1 Age-friendly is a global initiative to create a world in which everyone can live a long and healthy life. The Ageing Well programme board anticipate that Age-friendly Torbay could be a community banner to carry forward the work of Ageing Well Torbay and other community initiatives beyond March 2021.

1.2 The World Health Organisation leads on the global initiative, the 'WHO Global Network for Age-friendly Cities and Communities'. Age-friendly is not prescriptive, and there is no quality mark. There are 900+ Cities and Communities, 14 Network Affiliates, 41 Countries covering 230 Million People

1.3 In the UK the Age-friendly initiative is being led by the Centre for Ageing Better under Age-Friendly Communities.

1.4 Age-friendly involves agreement of a set of actions within a community – specific to the community's needs – aiming to support more people in later life to be in good health, financially secure, to have social connections and to feel their lives are meaningful and purposeful, at a pace and with resources that are available to the community. It is about adopting a particular 'lens' through which to view policies and services. It involves a multisector approach, with co-design, co-creation and meaningful involvement of older people at all stages. It is a life-course approach that focuses on reducing inequalities and supports inter-generational relations.

2. What has been achieved in the past six months?

2.1 Torbay (the Council, NHS organisations and Torbay Community Development Trust) joined the UK Network for Age-friendly Communities in January 2019. There are currently 36 age-friendly communities in the UK.

2.2 The overarching aim of the Torbay programme is a society where everybody enjoys a good later life. By 2040, we want more people in later life to be in good health, financially secure, to have social connections and to feel their lives are meaningful and purposeful.

3. What are the blockages?

3.1 No specific blockages currently identified other than resourcing general support to the programme beyond the conclusion of Ageing Well. The Ageing Well team currently provide some support to the Torbay Over Fifties Assembly in organising events and workplans.

4. What is the planned activity for the next six months?

4.1 Torbay partners are now looking to join the global WHO Age-Friendly network. The aim is to achieve membership by September / October 2020, to be announced at the Autumn Ageing Well festival.

4.2 Progress and plans against the requirements are below:

- Submission of a letter from the Council / community leader – the leader of Torbay Council has submitted a letter.
- Submission of an application including:
    - Baseline data survey: collected for the Ageing Well Programme
    - A summary of existing age-friendly actions taken: a meeting has been scheduled for 21 January 2020. Representatives of the Council, NHS, Torbay Community Development Trust and Torbay Over Fifties Assembly will start to compile a summary of relevant work covering 2015 to 2019.
    - A three year action plan developed by steering committee: there are plans to establish a steering group, meeting monthly, to prepare the action plan.
    - A commitment to provide images and a story of one new initiative, at least once a year.
- Agreement of priorities: the eight WHO Age-friendly domains have been discussed through wide consultations with older people and they form the framework for the Torbay Over Fifties Assembly (TOFA) work. Priorities will be agreed from among these areas:
    - Health and community support services
    - Communication and information
    - Participation and employment
    - Social participation
    - Respect and inclusion
    - Housing
    - Transport
    - Environment: Outdoor spaces and buildings.

4.3 Partners hope that groups like TOFA and the community partnerships will work closely with the Council, NHS and other key community organisations to continue to develop Age-friendly initiatives in Torbay.

4.4 Council, NHS, TOFA and Torbay Community Development Trust representatives are being sought to form a steering group which would meet on a monthly basis. Torbay Community Development Trust are happy to coordinate this while Ageing Well Torbay continues. Other Health and Wellbeing Board members would be very welcome to be involved.

(3) Enhanced Health in Care Homes (EHCH) - implementation in Torbay

1 Background

1.1 This briefing has been prepared to provide the Health and Wellbeing Board with an overview of the National Enhanced Health in Care Homes Framework (EHCH), and the partnership group recently established across the Torbay and South Devon system to support local implementation. It includes a brief update on work to improve oral health.

1.2 The health and wellbeing of people living in care homes is paramount, and approximately one in seven people aged 85 or over live permanently in a care home. Evidence suggests that the needs of people living in care homes are not always effectively identified, assessed and addressed. As a consequence this can result in unnecessary, unplanned and avoidable admissions to hospital for a variety of reasons.

1.3 The EHCH model published in September 2016 set out a Framework aimed at addressing the challenge though proactive, personalised care and support for individuals living in care homes or their local community who require support. The Framework was co-designed with six NHS-led vanguard sites in partnership with social care. The result was a suite of evidence based interventions that, when adopted within and around the care home in a co-ordinated approach, can maximise the benefit to the health and wellbeing of residents. The EHCH Framework forms part of both the NHS Long Term Plan and the General Practice Contract from April 2020.

1.4 The framework consists of four clinical elements and three enabler elements which are underpinned by nineteen sub elements (See table below). No one intervention will deliver sustainable change and it is through implementing and embedding all the elements of the framework that the greatest improvements can be achieved. This can only be successful through partners working in collaboration across the system.

1.5 The implementation of the framework aims to:

- Ensure the provision of high quality care within care homes through collaborative working between staff in care providers and the health and social care system;
- Ensure that, wherever possible, individuals who require support to live independently have access to the right care and the right health services in the place of their choosing;
- Ensure that we make the best use of resources by reducing unnecessary conveyances to hospital, hospital admission, and bed days whilst ensuring the best care for residents.

Care model element	Sub-element
Clinical elements	
1. Enhanced primary care support	Access to consistent, named GP and wider primary care services
	Medicine reviews
	Hydration and nutrition support
	Access to out of hours/urgent care
2. Multi-disciplinary team (MDT) support including coordinated health and social care	Expert advice and support for those with the most complex needs
	Helping professionals, carers and those with support needs to navigate
3. Reablement and rehabilitation to promote independence	Aligned rehabilitation and reablement services
	Developing community assets to support resilience and independence
4. High quality end-of-life care and dementia care	End-of-life care
	Dementia care
Enabler elements	
5. Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes
	Shared contractual mechanisms
	Access to appropriate housing options
	Equality and health inequalities
6. Workforce development	Training and development for care staff
	Joint workforce planning
7. Data, IT and technology	Linked health and social care data sets
	Access to the care record and secure email
	Better use of technology

1.6 Oral health has a big impact on the quality of life for everyone, including those living in care homes or receiving domiciliary care. Good oral care helps keep people free from pain – especially important to those who have communication difficulties, who may find it difficult to alert others where it hurts. For those with chronic conditions, good oral care can help make sure they can take the medicines they need. Good oral health can also reduce the risk of malnutrition, as well as reducing the risk of acquiring aspiration pneumonia, particularly in residential settings. NICE Guidance NG48 (2016), recognises the importance of good oral care. The recommendations aim to maintain and improve the oral health of adults in care homes (with many applicable to domiciliary care settings). [Smiling Matters (2019)]

2. What has been achieved in the past six months?

2.1 In July 2019 Torbay and South Devon NHS Foundation Trust (TSDFT) set up an EHCH Delivery Group. This group aimed to bring together partners working across on the system on specific elements of the EHCH framework under one umbrella. Members of the group include teams from Torbay and Devon Adult Social Care, Devon Partnership Trust, General Practice, NHS Devon Clinical Commissioning Group, Torbay Care Home board, Healthwatch and Torbay and South Devon NHS Foundation Trust. The aim of the group is to work in collaboration, and coordinate our approach to work in partnership with the care homes on achieving the aims of the EHCH care model.

2.2 The EHCH Delivery group has undertaken a comprehensive benchmarking exercise using the national EHCH bench marking tool to gain an appreciation and understanding of the work currently in progress across the local system.

Through the benchmarking exercise, areas for focus have been identified where work would be developed. In December 2019 the EHCH delivery group agreed on five key areas to work in partnership with the local care homes. These include:

- Personalisation in care homes;
- Systems and information sharing;
- Implementation of RESTORE2 (tool identifying if an individual's health is deteriorating and enable appropriate response);
- Education and training;
- Support for care homes from Health and Social Care partners.

2.3 With regard to oral health, Health and Local Authority sector partners have an ambition to improve oral health within care homes, domiciliary and supported living settings in Torbay. Our ageing population, significant numbers of providers, and recognition of the importance of good oral care on overall quality of life, provide momentum to this ambition.

2.4 Public Health recently sent a short seven question oral health survey to care home and domiciliary care providers, with returns due 22 January. Results will be presented and discussed at the provider forum on 28 January.

3. What are the blockages?

3.1 No specific blockages currently identified.

4. What is the planned activity for the next six months?

4.1 On 29 January 2020 an EHCH launch event is planned where the national EHCH care model framework will be shared with care home providers and other delegates. At the event local initiatives and work current will be shared and there will be an opportunity to co-design plans to take forward the five key areas outlined above.

4.2 The EHCH Delivery Group members will work in partnership to oversee the implementation of the EHCH care model. Five operational sub groups aligned to the five work streams outlined above will report into the Delivery Group where progress will be monitored and any challenges addressed. Each partner will have external reporting as required by respective organisations.

4.3 As we strive to provide high quality care across our health and social care system, implementing and embedding the EHCH care model will improve the health and wellbeing of residents and support our vision to provide person centred care closer to home.

4.4 Using the findings from the oral health survey, Public Health, in conjunction with the Peninsula Dental School and the Enhanced Health in Care Homes group, will develop a free training package that will help to overcome the day to day issues and barriers that providers face, and improve oral health for clients.

(4) Frailty and Falls – implementation of the Devon STP workstream

1 Background

1.1 The Frailty and Falls STP workstream sits within the STP Prevention programme and works across the whole of Devon to support implementation of evidence based interventions to prevent or delay the onset of falls, fractures and frailty.

1.2 Frailty is age-related but onset and deterioration may be delayed. It is related to deprivation and there is a 10-15 year difference in the onset of frailty across Devon. Frailty is the strongest predictor of health and care needs and costs.

1.3 The evidence tells us we should be doing a number of key things:

- Population level primary prevention: reducing smoking, increasing physical activity, reducing alcohol intake, promoting health diets, healthy weight and social engagement.
- Identifying and 'stratifying' people with falls and frailty risk, to guide what interventions will be most effective.
- Comprehensive geriatric assessment including falls risks.
- For people with severe frailty: full assessment of needs and wishes; shared care and support plans; high quality home care when needed; advance care planning for end of life care.
- For people with moderate frailty: proactive assessment and follow up; care planning; reducing inappropriate medications; falls prevention (eg. strength and balance training); carer support; home adaptations.
- For people with symptoms of mild frailty: primary prevention; support to self-manage their health conditions; falls prevention; strength and balance training; social activities.
- For everyone as they age: group based physical activities with strength and balance element; social interaction; cognitive stimulation; management of diet, weight, smoking and alcohol.

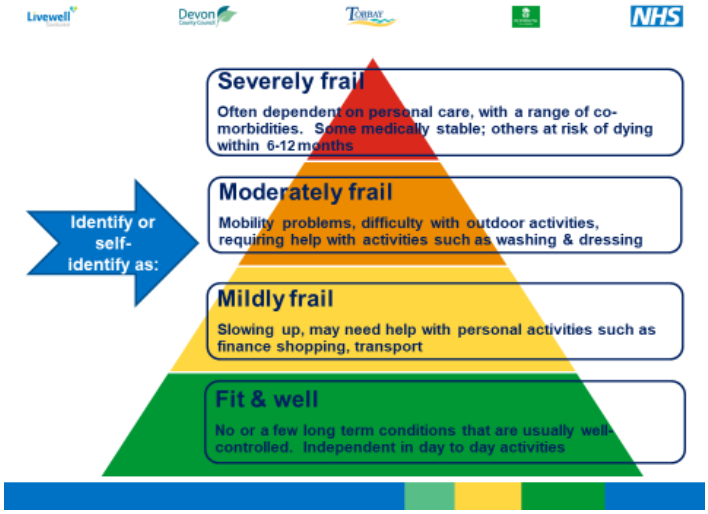
2. What has been achieved in the past six months?

2.1 The vision of the Frailty and Falls STP programme is that '*people in Devon live into older age with high levels of health and wellbeing. They live independently as long as possible, in a dwelling of their own choice'.*

2.2 Key areas for delivery across Devon are:

- Identification of people living with frailty:
  - Individually by clinicians using the 'Rockwood Clinical Frailty Scale';
  - In cohorts in primary care using a practice based frailty identification system;

- By people themselves in the community via online resources, campaigns, community groups, lifestyle services.



- Implementation of cost-effective interventions:
  - Assessment and shared care plans;
  - Falls assessment and referral for strength and balance training;
  - Referral via fracture prevention pathway for those experiencing a first fragility fracture;
  - Information and support to self-care, social prescription for physical / social activities;
  - Information and support for primary prevention (weight, diet, smoking, alcohol).

3. What are the blockages?

3.1 Funding sources for expanded falls and frailty services are not all recurrent. Project and change management resources are at a premium.

4. What is the planned activity for the next six months?

4.1 The Frailty and Falls STP is working with localities to support expansion of preventative pathways for falls and frailty. Two key objectives are the roll out of the practice level identification system, and introduction of fracture prevention service pathways across Devon.